DEPARTMENT OF THE NAVY
NAVAL HEALTHCARE SUPPORT OFFICE
BOX 140
JACKSONVILLE FL 32212-0140

INPUT THE FOLLOWING DATA PRESS TAB TO START

RANK RANK NAME NAME

SSN SSN DESIGNATOR DESIG

CORPS(DC,DT,MC,MSC,NC,WO) CORPS

This information will be used to fill fields on this form. Print out this form, follow the directions and send the package to us. Certified mail is the preferred way to return the package.

Print Package

Dear RANK NAME

Please provide copies of all checked items indicated in your E-mail and complete the forms in their entirety as identified in the cover letter and the following instructions.

USE ONLY BLACK INK
TO CORRECT AN ERROR, DRAW A SINGLE LINE THROUGH THE ERROR, IN BLACK INK, AND INITIAL TO THE RIGHT OF THE LINE.
DO NOT USE CORRECTION FLUID/TAPE UNDER ANY CIRCUMSTANCE

These guidelines should assist you with the completion of the **initial** package:

PERSONAL AND PROFESSIONAL INFORMATION SHEET (PPIS):

1. DEMOGRAPHICS:
Complete all information requested. Complete day/month/year time frames in the "from-to" fields. If the information is not applicable, write "**N/A**" in the space and draw a line through the remaining lines. Sign and date in the appropriate space. Please address the information regarding professional liability carrier and participation in continuing education.

Should you wish to attach a curriculum vitae/resume, ensure it is current. Please sign and date it with initials on each page in the lower right corner.

2. PROFESSIONAL EDUCATION AND TRAINING:
Provide copies of diploma for completed education/training (include Educational Commission for Foreign Medical Graduate (ECFMG) certificate as appropriate). CCPD is required to primary source verify these documents. **If this area is not checked on checklist, do not send credentials documents.**

3. & 4. BOARD CERTIFICATIONS/LICENSURE OR CERTIFCATIION BY STATE OR FEDERAL AGENCY:
Please provide copies of **all** current licenses/certificates held. CCPD is required to primary source verify all licenses/certificates held. Should you allow any to lapse/expire, please note this on the PPIS with an explanation as CCPD is required to primary source verify the document at time of lapse/expiration to evaluate status.

4c. DRUG ENFORCEMENT AGENCY CERTIFICATES (DEA)/CONTROLLED DANGEROUS SUBSTANCE CERTIFICATES (CDS):
Please submit a current copy of the DEA **and/or** CDS certificate (as applicable)

5. MEDICAL READINESS TRAINING:
Other contingency training documents may be submitted (BLS, ACLS, NRP, ATLS, C4, etc

6. HEALTH STATUS/ABILITY TO PERFORM:
Please respond to the questions that address this area. If you answer "**yes**" (except 6a) to any of the questions, provide a brief, factual response in the spaces below the questions.
Do not send a copy of a physical examination.

7. MALPRACTICE, LICENSURE, PRIVILEGING ACTION, AND LEGAL HISTORY:
Please respond to the questions that address this area. If you answer "**yes**" to any of the questions, provide a brief, factual response in the spaces below the questions. In addition you will need to provide the malpractice carrier name, address and phone number, policy number, dates of coverage and coverage amount.

8. PROFESSIONAL LIABILITY: Self-explanatory.

9. OTHER INFORMANTION: Self-explanatory.

10. RESERVE INFORMATION: Please complete the information regarding Naval Reserve Unit, Naval Air Reserve or Naval & Marine Corps Reserve Center, Naval Reserve Readiness Command as applicable.

11. RESERVE TRAINING: Self-explanatory.

12. CONTINUING EDUCATION HOURS: Self-explanatory.

13.PEER REFERENCES:
Ensure all addresses and phone numbers are complete and accurate.

PEER - is a person who has equivalent education and training, and has worked with you in same specialty.

PEER - *is not* a family member or partner.

Please complete the civilian employment/civilian facilities where privileges were held since completing the respective training program (i.e. Nursing School, Medical School, etc.). Provide the names, complete address and phone numbers of **two** peers who can attest to **current** competence for each specialty for which you are requesting core privileges. CCPD will mail two Professional Peer Inquiry forms (NHSOJAX 6010/3) and Civilian Employment Credential/Privileging Inquiry (NHSOJAX 6010/6) to the individuals that have been identified on your PPIS, for completion. In addition, a copy of your signed and dated consent and release form, a copy of the core privilege sheet(s) and a self-addressed envelope addressed to the Naval Healthcare Support Office will be included (so that the individuals can mail them **directly** upon completion).

The Centralized Credentials Review and Privileging Department (CCPD) will also send Civilian Employment Credential/Privileging Inquiry forms (NHSOHAX 6010/6) to your designated chief of service or medical director and/or the Human Resource Office/Credentialing Department at all places of employment held since obtaining your qualifying degree.

CORE PRIVILEGE SHEETS - INDEPENDENT PRACTITIONERS ONLY:
You should request core privileges to the maximum Naval Officer Billet Code(s) (NOBC) and Subspecialty Code(s) you hold and are assigned by the Bureau of Medicine and Surgery **and** where you can demonstrate current competence. Please include your BUMED assignment letter with your application.

Naval Healthcare Support Office may only approve and grant **core** privileges; should you desire **supplemental or itemized** privileges, you must request them from the gaining activity/mobilization site---Medical or Dental Treatment Facility.

CONSENT and RELEASE/PRIVACY ACT and DISCLOSURE STATEMENT
Please read, sign and date in the appropriate space.

INITIAL STAFF APPOINTMENT:
Initial "medical staff" membership (Bureau of Medicine and Surgery) and clinical privileges; the ECOM/DS recommends and the Privileging Authority, Naval Healthcare Support Office grants initial appointments for the core privileges only for a provisional period not exceeding one year. During this time the practitioner is given the opportunity to demonstrate to the privileging authority current clinical competence and the ability to comply with the facility's policies, procedures, bylaws, and code of professional ethics. This duration of time reflects the initial appointment period, which shall be proctored by a MTF/DTF.

APPLICATION FOR CORE PRIVILEGES - INDEPENDENT PRACTITIONERS ONLY:
The application is for Medical Corps officers, Dental Corps officers, Medical Service Corps/Chief Warrant officers (not Healthcare Administrators), and Nurse Corps officers (only Advance Nurse Practitioners as recognized by the Bureau of Medicine and Surgery). **Please sign and date the application for core privileges after completing section (1) and (3) on the form.**

Question 1 -- **initial only one request** as it relates to the core privileges that you are requesting for an **Initial Staff Appointment**.

(a) Initial core privileges are granted for <not greater than> a one year period in accordance with BUMED Medical Staff Bylaws.

Question 3 -- please read and **initial all blanks (a - g). The instructions that are referred to can be found on the CCPD Web page**

PHOTO:
Please provide a recent photograph, preferably a professional photograph of yourself **alone & without** other family members, friends or pets. It may be a Polaroid, but **not** a scanned or Xeroxed copy. Ensure that the photograph is labeled with your name, social security number and date.

OTHER PROFESSIONAL DOCUMENTS:
You may submit copies of any other associated training (CME/CEU) to your profession. This is **not** required, however, you will attest to CME/CEU participation on the PPIS and application for core privileges.

NATIONAL PRACTITIONER DATA BANK (NPDB) QUERIES:
CCPD must query the NPDB for independent practitioners requesting core privileges at the time of initial privileging and every two years thereafter.

Rev 01/00

NAVAL HEALTHCARE SUPPORT OFFICE
CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT
BOX 140 CODE CCP
JACKSONVILLE, FLORIDA 32212-0140

PERSONAL AND PROFESSIONAL INFORMATION SHEET
INITIAL PRIVILEGED PROVIDER

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.
PURPOSE: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and recommendations as to the practitioners' competence to treat certain conditions and perform certain medical procedures and to determine clinical support staff providers' competence.
ROUTINE USE: Information may be released to government boards or agencies or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in limitation or termination of clinical privileges.

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "YES" answers require full explanation in the comments section or an attached sheet of paper (indicate by number and section on the attached paper those items being commented upon.)

1. RANK NAME CORPS SSN DESIG

Maiden/Alias (Last, First, MI): _____

Date of Birth: _____ Branch of Service: USNR

Core Privileges requested: _____

NOBC/SSP codes: _____

Are you Board eligible (Y/N): _____ Are you Board certified (Y/N): _____

Home Address: _____

Home Phone: (___) _____ Fax: (___) _____ E-Mail: _____

Work address: _____

2. PROFESSIONAL EDUCATION AND TRAINING (list most recent first):

a. Basic Qualifying Degree (i.e. MD, DO, OD, MSW, MSN, etc.)

Institution (Name and Location)	Degree	From	To

b. Internship (INT), Residency (RES), Fellowship (FEL), additional Degrees

Institution (Name and Location)	Specialty	Type	From	To

RE: RANK NAME CORPS SSN DESIG

3. BOARD CERTIFICATIONS

a. Certification or Re-certification Issue Date Expiration Date

1. _____
2. _____

4. LICENSURE OR CERTIFICATION BY STATE OR FEDERAL AGENCY:

a. License Information

License # State Status Expires

1. _____
2. _____
3. _____
4. _____
5. _____

b. Certification Information

Certification # Cert Status Expires

1. _____
2. _____
3. _____

c. Drug Enforcement Agency/Controlled Dangerous Substance Number(s)

DEA/CDS # State Expires

1. _____
2. _____
3. _____

5. MEDICAL READINESS TRAINING (indicate trained "T" or instructor "I"):

Training	T/I	Expiration	Training	T/I	Expiration
BLS	_____	_____	ACLS	_____	_____
ATLS	_____	_____	NRP	_____	_____
C-4	_____	_____	CTTC	_____	_____

I hereby attest that I understand the requirement that I be certified in a CPR course provided by the American Heart Association/HEALTHCARE PROVIDER or the American Red Cross/PROFESSIONAL RESCUER while I am in the Naval Reserves per BUMEDINST 1500.15A. I understand that I am responsible for providing documentation of my certificate upon request (i.e. AT, ADT, IDTT).

Signature: _____ **Date:** _____

6. HEALTH STATUS AND ABILITY TO PERFORM (Answer YES or NO):

(Note: Explain all YES answers in Comments Section)

___a. Have you met the Navy's requirement to have a completed annual physical examination, either long or short form, within the past 12 months? (**If not, please explain**.)

___b. Do you currently have any physical or mental impairments that could limit your clinical abilities?

___c. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?

RE: RANK NAME CORPS SSN DESIG

___d. Have you ever been arrested or detained for an alcohol or drug-related incident?
___e. Have you ever been involved in the unlawful use of controlled substances?

Comments: _____

_____

_____

7. Malpractice, Licensure, Privileging Action, and Legal History (YES or NO):
(Note: Explain all YES answers in Comments section)

___a. Have you ever been denied a staff appointment or had your privileges suspended, limited, revoked, or had a renewal/appointment denied?
___b. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)
___c. Have you ever been the subject of investigation resulting in the termination of employment or a contractual arrangement?
___d. Have you ever been charged or a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)
___e. Have you ever voluntarily resigned or otherwise disassociated yourself from employment or practice after being notified of intent to start action against you for failure to properly accomplish your professional responsibilities?
___f. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated your staff appointment (membership)?
___g. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated, or lost your clinical privileges?
___i. Has there been previously successful or currently pending challenges, revocation, or restriction to any license, certification, or registration (State, district, or Drug Enforcement Agency) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?
___j. Are you now or have you ever been required to appear before any medical or state regulatory authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?

Comments: _____

_____

_____

8. PROFESSIONAL LIABILITY

a. Are you employed by a healthcare facility or agency and covered under their professional liability insurance? **YES** **NO** if **no** please answer questions (1) through (5) below.

(1) CARRIER NAME/PHONE NUMBER: _____

(2) CARRIER ADDRESS: _____

(3) POLICY NUMBER: _____

(4) AMOUNT OF COVERAGE: _____

(5) DATES OF COVERAGE: _____

RE: RANK NAME CORPS SSN DESIG

9. OTHER INFORMATION (Include any additional information that you wish to bring to the attention of the privileging authority.)

_____

_____

10. RESERVE INFORMATION

a. RESERVE UNIT and RUIC: _____

b. READINESS or RESERVE CENTER and UIC: _____

c. NAVAL AIR RESERVE OR RESERVE CENTER: _____

d. READINESS COMMAND (REDCOM): _____

e. BILLET ASSIGNED: _____

11. RESERVE TRAINING

a. OIS/DCO (Officer Indoctrination School /Direct Commissioned Officer School)
Completion Date: _____

b. List ANNUAL TRAINING (AT), ACTIVE DUTY FOR TRAINING (ADT), and ACTIVE DUTY FOR SPECIAL WORK (ADSW) during the past two years.

Facility/Location	Clinical	From	To
(Example) NH Groton	YES/NO	12SEP94	29SEP94

_____

_____

c. Do you perform drills at a military treatment facility? _____
If yes, provide information listed below:

Facility/Location	Capacity	Frequency
(Example) NH Jacksonville	Orthopedic Surgeon	48 drills/year

_____

_____

12. CONTINUING EDUCATION HOURS

Have you fulfilled your state licensure requirements for continuing education during the past 2 years?
_____**YES** _____**NO** (If not, please explain.)
Have you participated in continuing education in each requested area of specialization during the past 2 years (i.e., Flight Surgery, Internal Medicine)?
_____**YES** _____**NO** (If not, please explain.)

Comments: _____

_____

RE: RANK NAME CORPS SSN DESIG

13. DEPARTMENT DIRECTOR/CHIEF OF SERVICE REFERENCE:
Name ________________________________Work Phone ( ) ______________FAX ( ) ____________
Full Address ____

14. PEER REFERENCES Please provide two peer references (same specialty, i.e. Clinical Dietician/Clinical Dietician, Internal Med/Internal Med, General Dentist/General Dentist, Family Nurse Practitioner/Family Nurse Practitioner) who can attest to your qualifications in core specialty **based on current clinical experience within the past two years. NOTE:** Two peers are required for each set of core privileges requested.

Name ________________________________Work Phone (___) __________FAX (___) ___________
Full Address ____

Name ________________________________Work Phone (___) __________FAX (___) ___________
Full Address ____

15. PROFESSIONAL ASSIGNMENTS Please provide all information requested for each place you have been employed/held privileges since completing your respective training program (i.e. Medical School, PA Program, FNP Program, etc). Indicate if direct patient care was involved. If yes, **was it in your current specialty**?
List in chronological order with the most recent first, and identify gaps in employment history.

Facility/Institution ________________________PHONE (___) ______________FAX (___) __________
Address ____
Direct Patient Care (Y/N) ____________if yes how many hours per week__________________________
Privileges held (Y/N)____________________Position/Specialty _________________________________
Point of Contact ________________________________From ______________To ________________

Facility/Institution ________________________PHONE (___) ______________FAX (___) __________
Address ____
Direct Patient Care (Y/N) ____________if yes how many hours per week__________________________
Privileges held (Y/N)____________________Position/Specialty _________________________________
Point of Contact ________________________________From ______________To ________________

Facility/Institution ________________________PHONE (___) ______________FAX (___) __________
Address ____
Direct Patient Care (Y/N) ____________if yes how many hours per week __________________________
Privileges held (Y/N)____________________Position/Specialty _________________________________
Point of Contact ________________________________From ______________To ________________

Facility/Institution ________________________PHONE (___) ______________FAX (___) __________
Address ____
Direct Patient Care (Y/N) ____________if yes how many hours per week__________________________
Privileges held (Y/N)____________________Position/Specialty _________________________________
Point of Contact ________________________________From ______________To ________________

RE: RANK NAME CORPS SSN DESIG

Facility/Institution ____________________________PHONE (___) ______________FAX (___) ___________
Address ____
Direct Patient Care (Y/N) _____________if yes how many hours per week___________________________
Privileges held (Y/N)_____________________Position/Specialty _________________________________
Point of Contact __________________________________From _______________To _________________

Facility/Institution ____________________________PHONE (___) ______________FAX (___) ___________
Address ____
Direct Patient Care (Y/N) _____________if yes how many hours per week___________________________
Privileges held (Y/N)_____________________Position/Specialty _________________________________
Point of Contact __________________________________From _______________To _________________

Facility/Institution ____________________________PHONE (___) ______________FAX (___) ___________
Address ____
Direct Patient Care (Y/N) _____________if yes how many hours per week___________________________
Privileges held (Y/N)_____________________Position/Specialty _________________________________
Point of Contact __________________________________From _______________To _________________

** If currently working in a non-clinical setting, or working less than 10 clinical hours a week, briefly describe your current occupation and job activities**:

I affirm and attest that the information I have provided is complete and correct. I have the responsibility to comply with Medical/Dental Staff policies and procedures, and BUMED Bylaws and Code of Ethics/Standards of Conduct. I will keep my file current by informing the Naval Healthcare Support Office, Jacksonville, Florida of any changes, including but not limited to: my demographic information, my state license(s)/certification(s), any change in my medical staff/employment status at any facility, any change in my professional liability insurance coverage, or the filing of a lawsuit against me.

Signature: ______________________________________ Date: ______________________

INDIVIDUAL CREDENTIALS/PROFESSIONAL FILE

CONSENT AND RELEASE/PRIVACY ACT STATEMENT

RE: RANK NAME CORPS SSN DESIG

As a clinical support staff member or by applying for medical/dental staff membership of the Naval Healthcare Support Office, Jacksonville, Florida, I hereby make the following authorizations:

REFERENCES: Authorize the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives to consult with my current and prior associates and others who may have information regarding my clinical competence and other qualifications and to verify information in my file;

INSPECTION OF RECORDS: Consent to the inspection by the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, of all records and documents, that would evaluate my competence and professional, moral, and ethical qualifications;

LIABILITY INSURANCE: Authorize release of information from current and prior liability insurance carrier(s) regarding any and all information related to coverage and claim history under their company(ies);

RELEASE FROM LIABILITY: Release from liability any and all individuals and organizations who provide information to the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, in good faith and without malice concerning my clinical competence, ethics, moral character and any other qualifications. (Peer review activities are protected under the Health Care Quality Improvement Act of 1986 (HCQIA).).

TIME FRAME FOR AUTHORIZATION: Acknowledge that this form and any copies thereof may be used as authorization for securing information for two years from the date signed.

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

2. **PURPOSE**: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials and privileging function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

3. **ROUTINE USE**: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

4. **DISCLOSURE IS MANDATORY**: In the case of all personnel, the requested information is mandatory because of the need to document all credentialing and quality assurance (performance improvement) data. If the requested information is not furnished, further action on your ICF/IPF will not be possible. This all inclusive privacy act statement will apply to all requests for personal information made by personnel for credentials review purposes and will become a permanent part of your ICF/IPF.

Your signature acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

	SSN	
SIGNATURE OF MEMBER	SSN OF MEMBER	DATE

DATE:_____

From: RANK NAME CORPS SSN DESIG
To: Officer in Charge, Naval Healthcare Support Office, Jacksonville, FL 32212-0140

Subj: INITIAL STAFF APPOINTMENT WITH CLINICAL CORE PRIVILEGES

Ref: (a) BUMEDINST 6320.66B

Encl: (1) BUMED Assignment of Medical Department Classification (NOBC)/Subspecialty (SSP)/Additional Qualification Designator (AQD) Codes ltr of _____
(2) Clinical Core Privilege Sheet(s)

1. I request a Staff Appointment for the attached core privileges based on Subspecialty Codes assigned by the Bureau of Medicine and Surgery in enclosure (1).

(Please initial by request)

a.___An Initial Staff appointment with clinical core privileges as reflected in enclosure (2).

2. My Individual Credentials File provides information to support this application.

3. I certify that (Please initial each area):

a. ___I possess the credentials and current clinical competence to request the clinical core privileges for staff appointment.

b.___I have the ability to perform clinical core privileges requested.

c.___I have access to and agree to comply with the applicable credentials review and privileging directives.

d.___I have been provided a copy of have, access to, or have read, and agree to comply with Medical/Dental Staff policies and procedures, and BUMED Bylaws and Code of Ethics/Standards of Conduct.

e.___To my knowledge, I am not currently under any investigation involving substandard clinical practice, malpractice, or personal misconduct.

f.___I pledge to provide for the continuous care of my patients as predicated on professional ethics.

g.___I participate in continuing education in accordance with regulatory guidelines.

_____ _____
Signature Date